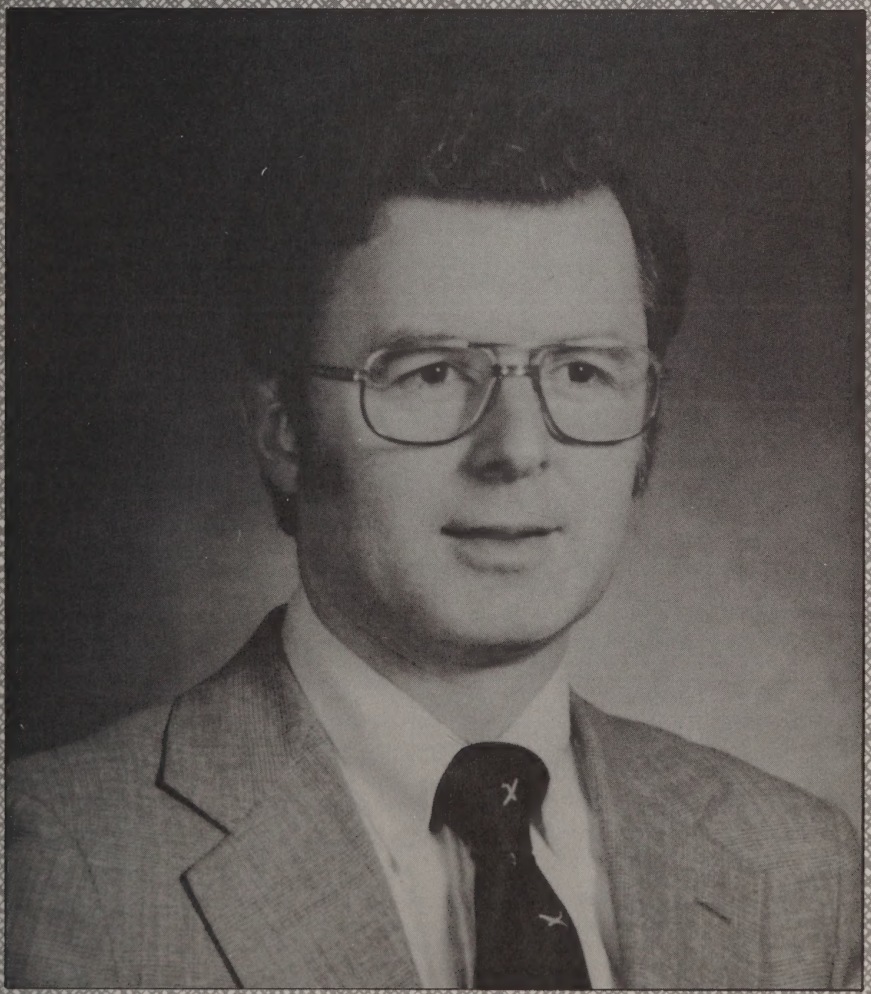
The Hampden Hippocrat

May 1981



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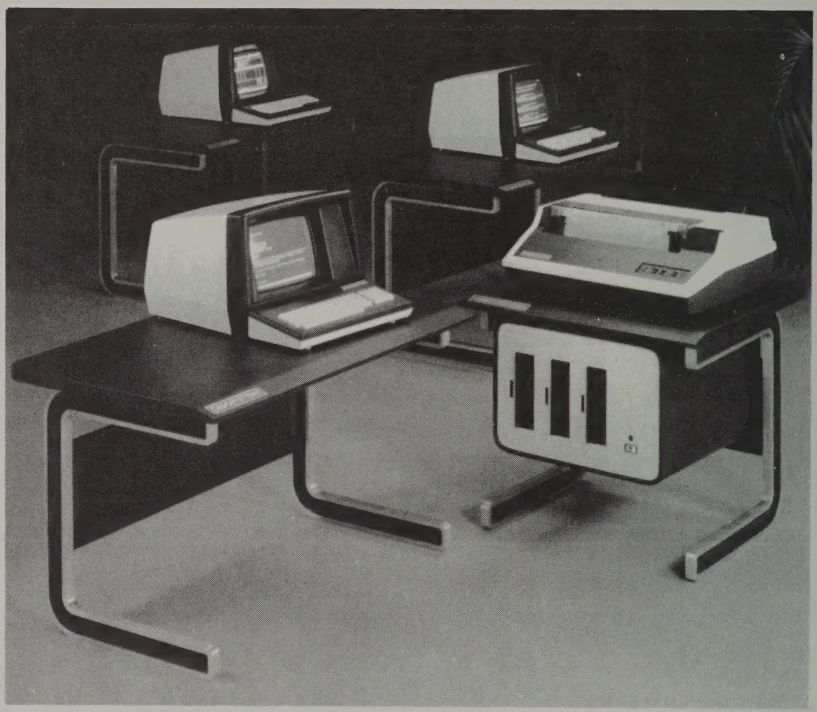

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(See open letter inside)

May 1981

The Hampden Hippocrat

Bulletin of the Hampden District Medical Society

This Magazine is published and distributed each month as a member service by the Hampden District Medical Society

OPEN LETTER TO ALL PHYSICIANS:

Dear Colleague:

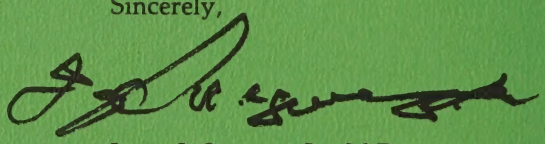
I feel compelled to remind you of the increasing importance of supporting organized medicine at all three levels of the Federation . . . your district—Hampden District Medical Society . . . your state—Massachusetts Medical Society . . . and nationally, the American Medical Association.

If you are already a member of Hampden District, MMS and AMA, we thank you for your support. If you are a non-member of one or all three levels, I encourage your participation and urge you to become a member. Please read through this issue of the *Hippocrat* for details on membership benefits.

An application form is enclosed for the Hampden District and MMS with a business reply envelope. The yellow form may be used for AMA membership and sent directly to AMA. If you have questions about the Federation, please contact the staff at 736-0661.

I hope you will respond to this invitation now.

Sincerely,



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1942

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
ALL COMMUNICATIONS SHOULD BE ADDRESSED TO VIVIAN M. PURDY, HAMPDEN DISTRICT MEDICAL SOCIETY, 1414 STATE ST., SPRINGFIELD, MASS. 01109; TELEPHONE: 736-0661.
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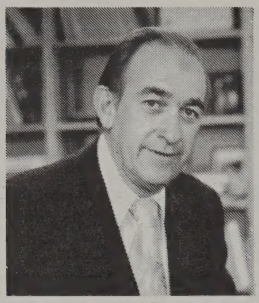

J.J. SIRAGUSA, JR., M.D.
President

PRESIDENT'S PAGE

FROM A LIBERAL

You may have heard it said that I am a liberal. There is a very good reason for that. I am.

When one accepts assignment to a category ones definition of that category is likely to be kindly. I define a liberal as one whose political motives are primarily social and humanitarian as opposed to economic and pragmatic. This brings with it a distain for excessive profit taking and a strong sense of responsibility towards the needy and disadvantaged members of our society.

My experiences of the past two years, one as your President and one year in preparation for same, have been a tremendous teaching experience for me. This has been augmented by my presence on the State Society Council and by my appointment a year ago as Delegate to the American Association of PSRO's. Prior to that time my involvement in the medical arena had been peripheral through my association with the politics of individual hospitals, involvement in our PSRO and our health planning organization. By the nature of my responsibilities these past two years I have been forced to assume the role of ''Physicians' Advocate''. The experience has been enriching. My perspective has a new lens which is at least 30 millimeters short. With it I perhaps lose some details but the wide angle is enlightening.

How has this affected my liberalism? Any philosophy needs to have goals and objectives. My philosophical concepts have not changed. However my understanding of the processesses that are necessary to accomplish the goals of a liberal philosophy have been considerably modified.

A physician's carrot is an ill patient for whom he feels compelled to care for irregardless of whether or not he or she has ''Master Medical''. A deeper understanding our system of tax supported medical care has made me realize that our charitable inclinations have been grossly abused by both individuals and the State. The knowledge that we providers recognize our responsibility to care for the needy and underprivileged has caused many citizens to inappropriately declare themselves to be needy or underprivileged. The State has done everything in it's power to encourage this abuse. By its regulatory activities and methods of reimbursement the State has forcefully directly abused our charity.

I have also learned a few things about how our government functions. There are two major groups with which we must deal. The first is our legislatures, the second our government agencies. The

Legislatures are made up of people for whom I have developed considerable respect. They are in general hard working, conscientious, knowledgable, and responsive people. The members of our government agencies, however are a different breed. They are too often haughty, inelastic, unapproachable and unresponsive. It is their role to create and enforce regulations. Government agencies have a much larger political clout than is apparent. They are strongly influenced by special interest groups and form tight little triangles among these groups, themselves and individual legislators. We can break these triangles only through our legislators.

There is a great wave of enthusiasm in our politics to push back the forces of over regulation and control. These forces are stifling our individual initiative and charity. We must make room for the good that can come of free enterprise combined with individual initiative and responsibility. We can be good Americans only if we are allowed to do so with pride.

Such changes are in no way contrary to the goals of a liberal society but rather help to attain these goals like a society most of whose individuals will be more prosperous and proud of their individual initiative and sense of responsibility towards their less fortunate brothers.

Standing on the shoulders of my predecessors, I believe that I have accomplished some forward motion for the Society during this past year with the help of the other officers of the Society and my committees. I am deeply grateful to them for their support and for having put up with my heckling. I am particularly grateful for the support and guidance of our President in perpetuam, Mrs. Vivian Purdy.

From the bottom of my heart, I thank you all for allowing me to be your president. □

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OF TIME AND THE RIVER

One Spring day in 1614 a Dutch trader named Adriaen Block was making his leisurely way homeward from New Amsterdam where two years earlier a handful of his countrymen had established a temporary trading post. As Block navigated by way of Long Island Sound he sighted on his port side a broad river with sandbar at its mouth over which the tide rose and fell. The scene looked inviting to the sailor and his crew so they turned their little craft upriver. Not until the ship had ascended to the bend where Middletown is now were any Indian settlements seen, but after that there were scattered native villages on both banks. The explorers probably came north as far as Windsor.

In the next dozen years the Dutch purchased some potentially valuable island property for $24 and shortly thereafter established posts along the Connecticut River near and above Hartford, primarily to trade with the natives for beaver skins. Unwittingly they bartered with lethal coin. What they bought with them was smallpox.

During the winter of 1633-34 three or four of the traders spent considerable time in an Indian stronghold described as "a great way from their trading house there." This is now interpreted as being as far north as Northampton or possibly even Northfield. The results were disastrous, and Governor Bradford, writing from Plymouth stated, "...and it pleased God to visit these Indians with a great sickness and such a mortality that of a thousand, above nine and a half hundred of them died, and many of them did rot above the ground for want of burial." In the spring the villages near Windsor were stricken and many more "fell sick of the smallpox and died most miserably; for a sorer disease cannot befall them." This may explain the fact that when two years later William Pynchon came to negotiate for land in Springfield he found scarcely a dozen natives with whom he had to deal.

Although William Pynchon deserves credit for priority, courage and vision, he became embroiled in a petty squabble with the clergy and scampered back to England after 16 years of frontiership. His son John stuck it out until his death in 1703 when the settlement had endured savage raids, floods, famine and destruction, but by then had become viable on its own.

John Pynchon married Amy Wyllys, the daughter of the colonial governor of Connecticut, and thereby acquired an ailing wife. Making a

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modern clinical diagnosis of Amy Pynchon's health problems after a lapse of more than three centuries might seem absurd, but we do have some useful data. She did have metrorrhagia, possibly a bleeding uterine fibroid. Certainly it was not a malignancy because she lived for another 30 years. She also had malaria, or, as it was known then, "the ague." Amy Pynchon does not seem to have started an epidemic of ague in this neighborhood, at least I have found no record of one at the time, although there were many cases among the Dutch in New York and the English in eastern Massachusetts and in southern Connecticut.

Another recorded instance of malaria was that of the Reverend Stephen Williams who arrived in Longmeadow from southern Connecticut about 1714, and presumably it was from there that he brought his feverish cargo. His diary for May 14, 1716 states: "This day I had a very bad fit of ye feavor & ague." For the next two months there are frequent references to "a bad fit of ye Ague". Although the Reverend Williams was not the only sufferer from Malaria in these parts of the next few decades, only rarely have its victims left us as enlightening a description of their miseries.

Then something strange and inexplicable happened. About 1750 malaria retreated from New England and did not reappear in the region for several decades, although the disease continued to flourish in New York, New Jersey and further south where it frequently harassed the British troops during the Revolution.

When the warfare and the economic ills that immediately followed were over, there was a period of growth and prosperity among the towns along the Connecticut River. Transportation of goods northward and materials, principally lumber, downstream was hindered by the falls at South Hadley. Because of this obstruction to water traffic a group of about twenty citizens from Springfield, Northampton and other surrouding towns were incorporated by the legislature to build a canal.

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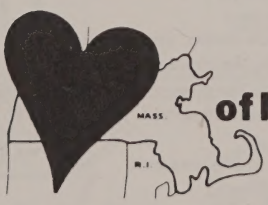
In The Hart  **of New England**

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The canal, part of it dug through solid rock, was two and a half miles long, and wide enough to accomodate a boat 16 feet wide. Although locks had been used in Europe their construction apparently was not understood hereabouts so instead an inclined plane was built. This was constructed at the upper end of the canal, made of stone and topped with planks. It was 230 feet long with a vertical lift of 53 feet. A car moving up and down this ramp consisted of a water tight box with folding gates at each end. Three sets of wheels, like big wagon wheels graduated in size so that the car maintained a horizontal posture at all times, were attached. At the head of the plane, on either side of the channel, were two overshot water wheels, 16 feet in diameter. These wheels, operated by water, pulled the car up or let it down, according as the gears were shifted. A boat ascending the river would be floated into the car and secured, the gates closed, the water in the car emptied through sluices at the sides. Then at the upper end the water was let upon the water wheels which wound up chains attached to the car and so drew it up the ramp to the top, and so out to the river.

When originally constructed the canal bed was too high to take in enough water for proper flotation. The solution was to build a dam eleven feet high across the Connecticut, but that created new problems. The dam raised the water level to the north all the way back to Northampton. In consequence the spring freshets left great quantities of stagnant water, the inhabitants were afflicted with fevers and ague, a disease unknown in that neighborhood for sixty years, and they were

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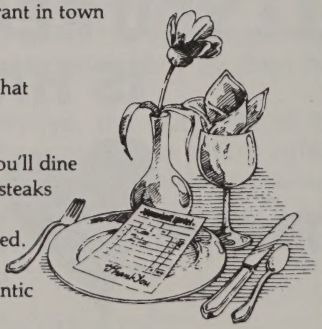

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unhappy. The feverish citizenry had to take their illness lying down, but not those they considered the perpetrators. Suits under the nuisance law were instituted against the canal proprietors who were compelled to dismantle the dam. Fresh capital was now needed to lower the bed of the canal by four feet for its entire length. In 1802 the legislature granted the company a lottery to raise $20,000 for this purpose. After this the canal functioned until the advent of the railroad.

In its early days the village of Springfield was located on a strip of land along what is now Main Street between the river and what became known as the town brook, a sluggish and swampy stream about where Market Street is now. The swamp extended to the foot of a sharp bluff between Dwight and Chestnut Streets. This meandering course served as a drain for the marsh and was something of a nuisance. We are told that about the year 1800 the residents became negligent, the town brook became filled with rubbish and the eastern meadows overflowed and caused sickness. We do not know that the sickness was malaria, but it is a strong possibility.

For the next thirty years, although there was an enormous amount of infectious disease in the valley, the afflictions that plagued the population were, for the most part, influenza, scarlet fever, typhoid fever, diphtheria, pleurisy and tuberculosis.

About 1830 there was a return, particularly in southern New England, of malaria. Although cause and effect might be difficult to prove, this was the era of active canal building, and hence interference with natural drainage. There were, for example, the Windsor Locks canal, circumventing the Enfield rapids, and the Farmington canal from Northampton to New Haven, circumventing the businessmen in Springfield and Hartford.

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From about 1832 to 1850 a large number of Irishmen came to Springfield. A few of them were to work in the Armory but most of them went to work building the railroads. The pay was very poor and the living conditions were awful. They lived in shacks on Ferry, Liberty and Sharon Streets but the worst place was Mechanics' Row, an alley running from Water Street (now Columbus Avenue) to the railroad tracks about opposite Bliss Street. When the river overflowed its banks, as it often did with the spring freshets, the Irish dwellings were the first to be submerged. There were no relief agencies, the suffering was acute and many of the impoverished laborers and their families lived out in the open until the waters subsided. The floods turned the river banks into swamps and breeding grounds for mosquitoes and malaria, pneumonia and other infections returned.

About 1850 some Boston entrepreneurs raised $75.00 to build a power dam just above the Hadley Falls at Holyoke. The first dam was largely made of heavy timbers and planks, but the builders did not take sufficiently into consideration the force of the water it was to withold. When the structure was completed the first day's progress was reported by telegram to the proper Bostonians in this manner:

10 A.M. Gates just closed; water filling behind dam.
12 M. Dam leaking badly.
2 P.M. Stones of bulkhead giving way to pressure
3:20 P.M. Your old dam's gone to hell by way of Willimansett.

A year later the second much stouter dam was completed and this one held and allowed the construction of Holyoke's elaborate three level canal system, the development of what was to become the largest industrial complex in this part of the world, and the worst health conditions the Connecticut Valley had ever witnessed.

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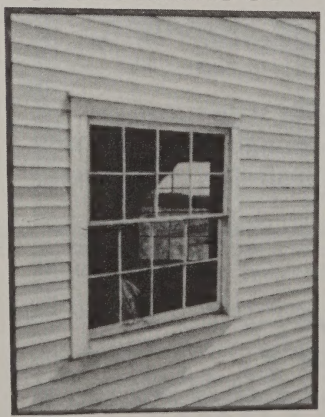

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The products of Holyoke industry in the 19th century were such things as paper of all kinds, textiles of many kinds, leather, yarn, thread, wire, hardware and many other items too numerous to list. The by-products were slums, two slums, one on the river bank above the dam known as the Patch, the other close to the river below the dam known as the Flats. Here was the only cheap land where the laboring class, mostly Irish and French Canadians could afford to live. Living conditions were execrable, diseases which included smallpox, scarlet fever, diphtheria, malaria and tuberculosis were rampant and the death rate matched that of the worst slums in New York City.

Downstream in 1855 Hartford was drinking Connecticut River water, but within a few years upstream dumping caused so much pollution that the city was compelled to find another source. Then for an entire century the situation literally worsened every year. Mill waste, garbage, sanitary sewers, storm drains, dead animals, dead fish, tin cans, oil barrels, old tires--you name it--everything imaginable was disposed of in the river. The stream was described as too thick to see the tip of a canoe paddle in, but not quite thick enough to walk on.

Given a chance a river will clean itself in about seven miles. Vegetable matter will settle out in that distance and beneficial bacteria will break down sewage if the organisms have oxygen to work with. The oxygen is obtained from the air from plants that grow in the water. Also in that distance chemical wastes will be so diluted as to become harmless. But when the pollution occurs again and again and again atmospheric oxygen cannot penetrate the oily surface and green plants cannot exist, dilution does not occur, fish cannot survive and the river is dead.

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In 1951 a United States Public Health Survey of the Connecticut River found 567 significant sources of pollution and only 60 treatment facilities that were considered adequate. The following year a group of concerned business men and conservationists banded together to form the Connecticut River Watershed Council to work with regional planners, state engineers and federal commissions to try to forestall further threats to the stream and expedite pollution control, but it was slow work. In 1956 a Federal Water Pollution Control Act was passed to help communities build waste treatment facilities, but it was feeble legislation.

A conference on the status of the river was held in 1963. At that time Senator Abraham Ribicoff described the official classification of the river as "Suitable for transportation of industrial wastes.....and for power, navigation, and for certain industrial uses." In 1965 Congress passed an amendment which gave the Water Pollution Control Act broader powers and established standards for clean water. In 1971 the state ordered Springfield to stop dumping untreated sewage into the Connecticut River, and Washington established the Environmental Protection Agency. Further amendments to the water pollution act provided that clean-up procedures would be funded: 75% by the federal government, 15% by the state and remainder by local communities. In 1975 some 54 million dollars became available for the treatment plant on Bondi's Island and the light of a new day was beginning to break over the river.

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This is not to say that problems have suddenly evaporated. The water above the Holyoke dam is now class B, which means it is suitable for boating and swimming. Below the dam it is still a mess. Bondi's Island is, as yet, a faltering step in the right direction. Holyoke's treatment plant is under construction and hopefully will go on line within a year. Connecticut from Enfield to tidewater is still dragging its dirty feet.

Many years ago I knew an elderly lady who told me that in winter, when she was a girl, the young people used to have skating parties from Agawam down to Thompsonville. Nowadays it would take a bold mouse to venture out on the ice. Once the river was a broad highway for Indians with canoes made from hollowed logs. It has been crossed and recrossed by ferries. It has seen intercollegiate boat races, canoe regattas, pleasure steamers and outboards. It has been harnessed, diverted, dammed, diluted, polluted and ignored. Usually the river is calm and peaceful, but occasionally it throws off its placid mantle, goes into an utter rage, becomes a torrent destroying everything in its immediate path, perhaps only to demonstrate that it has a power and a personality all its own.

It starts just south of the Canadian border and up there a small boy can jump across it. Four hundred and ten miles downstream it is nearly a mile wide and here the ocean tides clean it again. Man marks the earth with ruin, but the river begins clean and ends clean, no matter how we desecrate it--for the river is eternal. □

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In Memoriam

THOMAS M. TEREE, M.D.

Thomas M. Teree, M.D., Chairman of the Department of Pediatrics at Baystate Medical Center, Professor of Pediatrics at Tufts and University of Massachusetts Medical Schools, died at home on Saturday, February 21, 1981 at 49 years of age after a valiant battle with cancer. Dr. Teree left his wife, Helen, his children Jane, Laura, Ruth, Robert and Daniel, as well as many dear and loyal friends.

He was born in Detroit, Michigan but spent much of his adolescence and young adult life in Cleveland, Ohio. Dr. Teree was a graduate of the Johns Hopkins University and then received his medical degree at Western Reserve University. He attained high academic honors at both institutions, being elected to the Phi Beta Kappa Society at Johns Hopkins and Alpha Omega Alpha Society at Western Reserve.

Subsequently, he had two years of pediatric training at Children's Hospital Medical Center in Boston and then a final year of pediatric residency at the Children's Hospital in Cincinnati. He initially was a United States Public Health Service Postdoctoral Research Fellow in Pediatric Metabolism at Western Reserve from 1961 through 1964, then became a faculty member at that university, becoming Associate Professor of Pediatrics in 1970. During his tenure at Western Reserve, Dr. Teree was a John and Mary R. Markle Scholar in Academic Medicine, as well as being program director for the clinical research center for children at the university. His research interests involved acid-base balance and the assessment of skeletal metabolism in early childhood. During that period, Dr. Teree's clinical efforts were directed toward the care of a large number of children in Cleveland with juvenile onset diabetes mellitus, as well as the management of youngsters with such metabolic disorders as phenylketonuria.

Perhaps more importantly than these academic credentials, research interests, or clinical endeavors, Dr. Teree had a deep influence upon many medical students and house staff whom he met at Western Reserve. These young men and women were continually amazed by his clarity of thought, incisiveness of decision making, compassion for ill children, and the ability to extract important general pediatric therapeutic principles and guidelines from seemingly mundane clinical problems.

Seeking different challenges, Dr. Teree joined a community pediatric practice in Elmira, New York in 1970. In that setting, until 1976, his superior academic skills were utilized in the day-to-day activity of a rapidly-growing pediatric practice. A two-man partnership grew to a seven-man practice by 1976. Many of the new members of this group had trained at Western

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ADVANCEMENTS IN 1980

- 1209 visits were made by families to the WCHC for physicals, testing, health counseling, and referrals.
- 7824 individuals received home visiting services provided by the Public Health Nurses on referral.
- 3035 immunizations were given to children through age 18 by Public Health Nurses, contributing to the control of diseases such as: measles, mumps, rubella, polio, diptheria, and whooping cough.
- Tuberculin testing was done for 2013 individuals in the effort to control the spread of TB.
- 4086 flu and 1402 pneumonia immuniations were given at 13 clinic sites in the City.
- Dental Hygienists checked 8347 children for dental problems; 2942 were treated at dental clinics.
- 15,139 inspections were made by Health Inspectors to protect the health and safety of City residents.
- Licenses were issued to 648 food service establishments and 232 retail food establishments.
- 5926 laboratory tests were done on milk and food products, water samples, and utensil swabs.
- CHECCA (Community Health Education Council for Children and Adolescents) was established to raise awareness and mobilize resources to prevent alcohol and drug abuse among City youth.
- A planning committee was initiated to reorganize the Department's Annual Report and related data.
- Requests for "Choke Saver" educational programs continue to increase.
- Legislation was passed that increased the membership and expanded the role of the Public Health Council, the advisory body to the Health Department.

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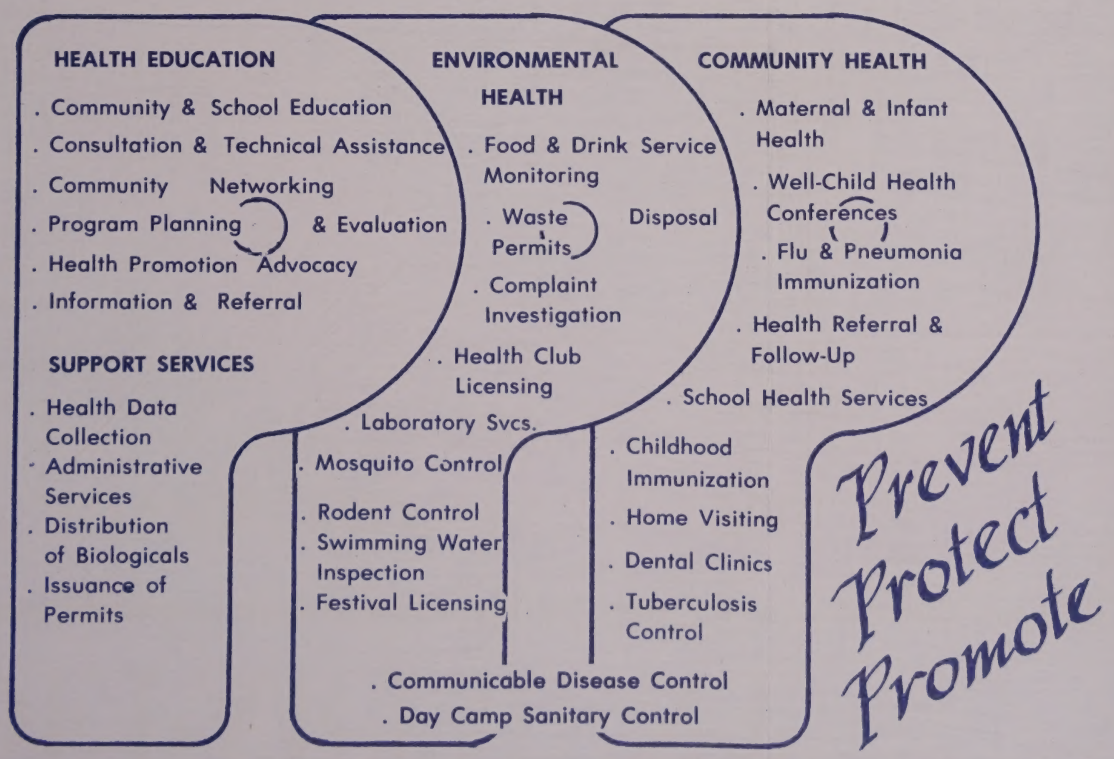

HISTORICAL INFORMATION

1832 - Health Committee appointed.
1852 - Board of Health Established.
1883 - First full-time Health Agent hired.
1900 - Board was reorganized to 3 members.
1923 - Expanded Board of Health.
1934 - Health Department established.

YOUR INVESTMENT IN PUBLIC HEALTH

1979 Health Department Expenditures.....	$ 991,805.00
Fees for Services.....	$ 80,198.00
Net per Capita Expenditures*.....	$ 5.97

*1980 Census

SERVING
152,500 (Est.)*
SPRINGFIELD
RESIDENTS

*1980 Census

PUBLIC HEALTH CONCERNS

SPRINGFIELD, MASSACHUSETTS

LEADING CAUSES OF RESIDENT DEATHS — 1979

1. Heart Disease	555
2. Cancer	345
3. Stroke	174
4. Accidents	79
5. Pneumonia & Influenza	48
6. Diabetes	39
7. Cirrhosis of Liver	23
8. Arteriosclerosis	21
9. Perinatal Diseases	18
10. Suicide	13
TOTAL ALL CAUSES	1552

SELECTED REPORTABLE RESIDENT CASES of COMMUNICABLE DISEASE — 1979

1. Strep Infections	1626
2. Gonorrhea	827
3. Chickenpox	373
4. Syphllis	45
5. Salmonella	35
6. Tuberculosis	32
7. Hepatitis	30
8. Scarlet Fever	14
9. Dysentery	12
10. Meningitis	11
Animal Bites	832
TOTAL REPORTED RESIDENT CASES	3849

SPRINGFIELD HEALTH DEPARTMENT
1414 STATE STREET
SPRINGFIELD, MA. 01109
PHONE (413) 787—6740

John C. Ayres, M.D., M.P.H.
Commissioner of Public Health

4/81

Reserve and had been strongly influenced by Dr. Teree during that formative period of their lives. The practice not only grew in size but in quality. A strong committment to neonatal intesive care, comprehensive assessment of children with learning disabilities, as well as to the general scope of pediatrics was made by this innovative pediatric group practice.

Again seeking new challenges, Dr. Teree became Chairman of the Department of Pediatrics at the Baystate Medical Center in 1976, taking over the reigns of a small department with great potential for growth. He recruited a number of sub-specialty trained pediatricians to greatly augment the teaching capabilities of the Department of Pediatrics, as well as to provide the types of tertiary child-health care which had previously only been available at larger university medical centers. Patients now rarely must travel from this region to receive modern, high quality care. The residency program has grown in sophistication and in capability. The residents and students were indelibly marked by a man of impenetrable integrity and extreme practicality. The students from Tufts honored Dr. Teree as a Teacher of the Year in the 1979-1980 academic year. Dr. Teree provided wise counsel to the medical center, focused its attention on the importance of children and their lives and health care in this era, and unceasingly labored to improve the lot of the infant and child, a patient without constituency, in a large and complex health care environment.

Dr. Teree's professional activities, however, afford but a mere glimpse at the man. He was an avid sportsman, enjoying the challenge of competitive bridge, and participating in frequent golf tournaments at the Longmeadow Country Club, having had one of the best golfing seasons of his life during the past summer. Despite limited vision, he performed remarkably well on the tennis court with extraordinarily quick reflexes at the net. He and his sons became avid stamp collectors with his usual preciseness being translated into this avocation.

It is difficult to accept the loss of a man with vision, compassion, intellectual gift, personal magnetism, and beyond all, the trust of friends. One can remember many admonitions, encouragements, detailed patient discussions, quick and penetrating witticisms, along with so many conversations regarding our roles in a rapidly changing health care world. Dr. Teree wrote, more than six months ago, that "in the course of time, you will realize that life flows from one generation to the next, and that the passing of a single person means a good deal less than his or her presence." As one whose life has been profoundly influenced by Tom Teree, his absence is incalculable and his memory ever-present. □

EDWARD O. REITER, M.D.

A Physician's View Of The Visiting Nurse Association

Home based health care of the sick and disabled is an important component of the health care delivery system. Each plan of care is individualized according to the needs of the patient. Each plan for home health care must be developed in collaboration with the patient's physician. This care plan is then implemented in the individual's home by coordinating professional nurse services with physical, speech and occupational therapies. The services of homemakers and home health aides are also available on a part-time, intermittent basis.

Such home health care is available from the Visiting Nurse Association of Springfield. Services from the V.N.A. are available to individuals of all ages and people of all diagnostic categories as well as all economic levels. These patients can be adequately cared for at home because their health problems usually do not require around-the-clock intensive care, or the use of specialized hospital equipment and monitoring.

Home health service, as offered by Visiting Nurse Associations, is gaining in recognition as an important alternative to hospital or nursing home care. It is, in fact, viewed by health planners as the first option to be considered prior to any institutional care, or to promote earlier discharge from the hospital.

The home, only a few generations ago, was the place by choice or necessity for the care of the sick. The family doctor, as well as members of the family, saw the patient through his illness. Home care is coming back, but better home care than was possible ever before---continuous, comprehensive and coordinated care---as available through the Visiting Nurse Association of Springfield.

Once the patient is at home after being hospitalized, the responsibility for professional nursing care and therapy services falls on the Visiting Nurse Association, which works closely with the family physician. The V.N.A. staff reports regularly to the patient's physician for any renewal or change of medical orders. The V.N.A. also coordinates the schedule of visits of other therapeutic services such as speech, occupational or physicial therapy that the patient may be receiving. The aim is to always restore the patient to his/her maximum level of health and independence as soon as possible.

Home care benefits everyone: patient, family, physician, hospital and community. The physician benefits from participation in a home care program because of the team approach between the physician and the professional visiting nurse. The collaboration of physician and registered nurse often reduces anxiety and concern of family members for the patient who needs home health care. Since home care frees hospital beds, the physician is able to hospitalize more people who require their medical attention as well as the services of an acute care facility.

Although home care is one of the least expensive and well organized

medical services, it is one of the least used and least appreciated health service. Services provided by the V.N.A. are provided on a fee-for-service basis. As a certified home health agency, the V.N.A. can bill third-party payors such as Medicare, Medicaid, Title XX, Title III and private health insurance companies. For those who do not have a third-party payor or who have exhausted benefits, the V.N.A. accepts payment according to the individual's ability to pay. Support from the Pioneer Valley United Way subsidizes individuals who cannot afford the full fee.

Physicians should take advantage of home care because it is voluntary and because they are responsible for the continuing medical management of their patients. The quality of home care services provided by the V.N.A. is assured with a Medical Advisory Committee, whose physicians set standards for home care medical policies and offer advice on medical matters.

Physicians can strengthen the most available building block to improve services for patients at home by referring cases to the Visiting Nurse Association. Services available include Nursing, Physicial Therapy, Speech Therapy, Occupational Therapy, Home Health Aides and Homemakers. Voluntary Care Givers are also available to assist patients with a terminal illness and to support family members.

The Visiting Nurse Association of Springfield provides home health care in ten communities in the Greater Springfield area. They are: Agawam, East Longmeadow, Hampden, Longmeadow, Ludlow, Springfield, Southwick, Westfield, West Springfield and Wilbraham. Patients in other communities may receive services from their local V.N.A.'s.

Call 781-5070 when your patients need professional health care at home in the Greater Springfield area. □

By William J. Baker, M.D.,
President, Board of Directors

Alexine L. Janiszewski, R.N., M.S.
Executive Director

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SOME RULES TO HELP YOU PREVENT MALPRACTICE CLAIMS

1. Provide your patients with care that meets the standard of good medical practice.
2. Do not criticize the work of other physicians in the presence of the patient.
3. Keep complete medical records.
4. Avoid impulsive remarks to the patient which may be construed as a guarantee of results or an admission of fault.
5. Good patient care requires frequent doses of tact as well as professional competence.
6. Refrain from overoptimistic prognoses.
7. Use consultation if the patient is not doing well or if he or his family show signs of dissatisfaction.
8. Have a clear understanding with the patient on fees before starting treatment.
9. Review the case before using pressure in collecting fees, particularly if there was an unsatisfactory result.
10. Know the statue of limitations which applies in your state to the period during which a patient sue for a malpractice claim.
11. If you wish to terminate a physician relationship, give the patient ample time to find another doctor so that he cannot claim abandonment.

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12. Check your equipment frequently for accuracy and safety.
13. Limit you practice to such fields as are within your qualifications.
14. Keep abreast of new developments in your area of medical science and new practice.
15. Assistants and employees should be carefully supervised and duties assigned in accordance with their qualifications and experience.
16. Obtain written consents to operations and autopsies.
17. Do not discuss your malpractice insurance with any patient or his family.
18. Obtain legal counsel if you are called to attend a coroner's inquest as a witness in a case in which you have been in professional attendance.
19. Except in cases of emergency, do not examine a female unless a third person is present.
20. Confirm phone prescriptions in writing.
21. Advise your patients of any intended absence from your practice and recommend, or **make available,** a qualified substitute.
22. Use accepted medical techniques with your patients.
23. Keep inviolate all confidential communications made to you by the patient.
24. When a patient who requires medical attention fails to keep an appointment, or discontinues treatment before he should, state the facts in aletter to him and retain a carbon copy in your files.

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AUXILIARY NEWS

On January 27, 1981 over sixty persons representing area medical auxiliaries, hospital personnel, members of HDMS, Hospice and several legislators attended "Health Care Legislation in the 80's" at Storrowton Tavern.

Mr. Harry Gifford, President of Baystate Medical Center, encouraged us to use the legislative process by first identifying the issue we want to support and then to let our legislators know our pros and cons. He emphasized that group desires can develop a more substantial impact on health care legislation than can any individual.

Mrs. Janet DesChenes, Co-Chairperson of the Massachusetts Medical Society Auxiliary Legislation committee, and who sits on the MMS's Legislation Committee, also emphasized that we as constituents, can influence votes. "We must assist the medical society to achieve its necessary ends." All of us should become aware of the legislative process and communicate with our legislators and their aides.

John Noonan, Director of the MMS's Governmental Affairs, also asked us to get involved and participate in the MMS's views on Health Care issues. Out of 900 1981 bills, 600 will be medically related. 54 lobbyists represent 38 health related fields.

If you want information about a specific bill, you must know the number that has been assigned to that particular bill. It is helpful if you know the title of the bill, the sponsor, and something about the content.

All bills are referred to a specific committee of the legislature for a public hearing and committee recommendation. Most bills are referred to the Committee on Health Care. For information on Health Care Committee bills, call the State House, 1-617-727-8137. For any number at the State House call 1-617-727-2121. □

AUDREY RICH,
Auxiliary Reporter

Museum Shop

Browse among our treasures daily (except Monday). Attend "Arts and Flowers" May 12 and 13 for an exhibition of floral arrangements, lectures, luncheon and tea. For details call or visit the Museum of Fine Arts, Springfield, 732-6092.

NOMINATING COMMITTEE REPORT 1981-82

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Murray Watnick
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Vincent A. Guardione

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Anthony P. Lovell
Edward D. McHugh

Hampden Capsules

Dr. Siragusa participated in a debate at Holyoke Community College on March 31, 1981 on "National Health Systems."

Dr. Bloom talked to law students at Western New England College on "Ethics and the Profession". On the program an attorney and an engineer talked about ethics and their profession.

Dr. Gallivan was interviewed on television after the attempted assassination of President Reagan to give his opinions of the operation.

Vivian Purdy, HDMS Executive Secretary, has just finished twenty years serving the society.

Dr. Simpson has just published a book entitled: "The Impact of Disease on American History."

Keep the HDMS office informed of your activities and they will be printed in the Hampden Hippocrat.

What a beautiful tribute to a fine physician --- Dr. Joseph P. Derby written up in Hampden County Enterprise the week of April 20, 1981. "A Memorable Man of Medicine" Dr. Derby gave confidence and help to his patient's welfare.

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What They're Saying...

HEALTH PLANNING

...the AMA does support the concept of health planning. We support it if it's voluntary in nature and local in character. And we support it if it is planning for the patient, rather than planning for government's sake or planning for planning's sake. Because real patient needs should be the first priority of government officials and health planners as well as the first priority of my profession.

Robert T. Kelly, M.D., Member, AMA Board of Trustees, Speech Delivered to the National Health Planning Policy Conference.

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LETTER TO EDITOR

Dear Doctor:

Carcinoma of the breast is the most frequent cancer and leading cause of cancer death in American women. Approximately 36,000 will die from this disease in 1981. One out of every fourteen women will develop carcinoma of the breast in her lifetime.

Mammography has been proven to be an invaluable tool in the diagnosis of breast carcinoma, and, if used appropriately, can reduce breast cancer mortality by one-third in women over age 50, and possibly in women under 50. It is our belief that this modality is underutilized in our area. The reason for this is probably two-fold:

1. Fear that the procedure itself will cause breast carcinoma, and

2. unawareness of the effectiveness of this procedure in the diagnosis of breast carcinoma at an early stage.

In 1976 mammography surfaced as an issue of intense public interest. It was a topic of discussion on television talk shows and newscasts. Articles appeared in newspapers and magazines. This sudden interest was precipitated by charges that the radiation exposure used in mammography caused more cancer than it found. Nothing could be further from the truth, but, nevertheless, the damage was done and result predictable. A precipitous drop in the utilization of mammography ensued nationwide, and the Greater Springfield area was no exception. Since that time numerous articles have appeared in the medical literature, placing the radiation scare in proper perspective,

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and pointing out the benefit of the examination. Unfortunately, little of this information has reached the lay public. Only recently the American Cancer Society has recommended that all women over the age 50 have annual mammograms, and that women under age 50, in certain risk groups, also have periodic mammographic examinations. We support these recommendations.

Still, resistance to mammography persists. You quite likely encounter it in your practice. This resistance must be overcome because if it is not, avoidable deaths due to carcinoma of the breast will occur.

In order to assist you and your patients, we are enclosing answers to questions you may have or may encounter in your everday practice. We are also enclosing our current recommendations as to the appropriate use of mammography. We hope this will be of assistance to you. Please do not hesitate to contact any one of us if there are questions we have left unanswered. If there are questions which you cannot, or prefer not to answer, instruct your patients to contact us, and we will do our best to provide answers.

"Guidelines for Mammography" and Questions and Answers on Mammography" and Questions and Answers on Mammography are available from the HDMS office upon request. Telephone: 736-0661. □

Sincerely yours,

W.M. Cloud, M.D.
Robert H. Dann, M.D.
Ernest M. Mittelholzer, M.D.
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Help Your Patients Stop Smoking Cigarettes

The physician plans a key role in helping smokers quit. A recent Gallup survey reveals that 71% of cigarette smokers would quit if their physician urged them to.

Now **The American Cancer Society has a Physician's Help Quit Kit** that gives doctors the tools they need to help them persuade their patients who smoke to quite.

The Physician's Help Quit Kit contains:

- Desk top and waiting room signs
- Smoker Labels for patient charts
- Strategic Withdrawal from Cigarette Smoking, an informative booklet dealing with the pharmacological satisfactions, the psychic and social effects of smoking, obstacles to quitting and alternatives to smoking
- Patient take home literature, including the
  1. "Quitters Guide" - a structured 7 day self-help quit plan
  2. "Smoker Calculator" - a unique insight into types of smokers
- Progress in Smoking Cessation - a recent State of the Art paper by Jerome Schwartz Dr. PhD, summarizing twelve current techniques used in helping smokers quit
- Health Thyself Quit - a brochure detailing local resources available to help smokers quit

A recent study conducted by Lieberman Research Inc. involved 500 physicians, and the use of anti-smoking literature. It indicated that a large majority of these physicians responded favorably to the use of this material. It showed that 82% felt that the kits should be distributed to other physicians and an even more impressive 94% felt that the patient take home literature should be distributed to other physicians tohand out to their smoking patients.

Highlights of the study included:

75% physicians felt it was extremely important for symptomatic patients to quit smoking
92% spoke to smoking patients about quitting in the past few weeks
63% felt extremely comfortable speaking to smoking patients about quitting.
40% were extremely forceful in speaking to smoking patients about quitting

This Physician's Help Quit Kit may prove to be the most effective weapon we've come up with for the prevention of lung cancer and a host of other smoking related diseases.

For a free kit call the American Cancer Society at 785-1545. □

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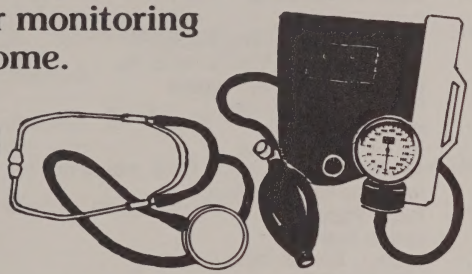

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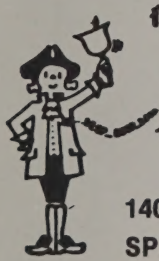

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